2014

Nationwide Life Insurance Company Home Office: Columbus, Ohio	Commonwealth of Kentucky Employee Group Life Insurance Program **Open Enrollment Form** **Group Insurance Contract: BE 0002**

OPEN ENROLLMENT -- SELECTIONS EFFECTIVE 1/1/2015

SSN	Location Name (Specify name or Agency, School Board or Health Dept.)		
Name (Last, First, MI)	Location Number	Birth date	
Address (Street Name/Number)	Annual Salary	Hire Date	Gender ☐Male ☐Female
(City, County, State, Zip)	Work Number	Home Number	

A. Basic Life and Accidental Death and Dismemberment (AD&D) Insurance

Eligible employees are insured at no cost to the employee for Basic Life and AD&D Insurance

All Eligible Employees $20,000 Cost: (employer paid)

B. Optional Life and Accidental Death and Dismemberment (AD&D) Insurance (Select One Plan)

I wish to _____enroll* in, _____change* to the optional insurance plan checked below: **(Select one plan only)**

Monthly Contribution

Age Band	Rate per $1,000
Under 40	**$0.24**
40-59	$0.60
60 and over	**$0.98**

☐ Plan 1 $5,000	☐ **Plan 3 (NEW)** **$25,000**	☐ Plan 5 1X Annual Salary**
☐ Plan 2 $10,000	☐**Plan 4 (NEW)** **$50,000**	☐ Plan 6 2X Annual Salary**

***Evidence of insurability may be required depending on the circumstances and/or for insurance over $150, 000.**

****Under Plans 5 and 6, insurance amounts will be rounded to the nearest multiple of $1,000. Amounts of insurance will increase with an earnings change.**

C. Dependent Life Insurance (Select One Plan)

Please ___ enroll* my dependents in, ___ change* my present plan to the plan checked below: **(Select one plan only)**

	□ Plan A	□ Plan B	□ Plan C	□ Plan D	□ Plan E
Spouse**	$10,000	$5,000	$5,000	$10,000	---
Dependent Children to 6 mos	$2,500	$1,500	---	---	$2,500
Dependent Children 6 mos to 18 yrs***	$5,000	$3,000	---	---	$5,000
Monthly Contribution	$11.46	$6.20	$2.62	$9.14	$3.78

***Evidence of insurability may be required depending on circumstances**

****Spouse means a person to whom you are legally married**

*****18 and older if attending an educational institution and relying on the employee for financial support**

E. Fraud Warning: Any Person who knowingly and with intent to injure, defraud, or deceive an insurance company or other person, or knowing that he is facilitating commission of a fraud, submits incomplete, false, fraudulent, deceptive or misleading facts or information when filing an insurance application or a statement of claim for payment of a loss of benefit commits a fraudulent insurance act, is/may be guilty of a crime and may be prosecuted and punished under state law. Penalties may include fines, civil damages and criminal penalties, including confinement in prison. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant or if the applicant conceals, for the purpose of misleading, information concerning any fact material thereto.

F. Employee Signature and Date (Required)

I, the undersigned, certify that I have read the completed enrollment/change/termination form and agree that all answers in this form are true and complete to the best of my knowledge and belief. I hereby authorize my employer to deduct from my paycheck or earnings the amount required to cover my share of the coverage I have selected.

Employee Signature _____ **Date** _____

IC/HRG Signature_____ **Date**_____

Send Copy to your Insurance Coordinator

Instructions

- Print all information using black or blue ink (if submitting a paper form.)
- Complete location name and number.
- Annual earnings are required when selecting Optional Plan 3 or 4.
- Select only one plan for Optional Term Life coverage.
- Select only one plan for Dependent Term Life coverage.
- Employee must provide evidence of insurability for coverage over $150,000. This must be approved by the insurance carrier before coverage can be initiated.
- Spouse is defined as a person to whom you are legally married.
- Child 18 or older can remain covered providing the child is a full-time student and relying on the *employee for financial support.*
- Employee signature and date is required (if submitting a paper form.)
- Insurance Coordinator should *verify all information* in ESS, or sign and date form.
- Description of Qualifying Event should be completed by the Insurance Coordinator. For example: Marriage only.
- Date of Qualifying Event should be listed as the last day employee worked or official date of termination, not when coverage will end.

For Board of Education employees with salary based plans, the new contract year salary will be effective 11/1 of each year.

Premium rates are effective as of January 1, 2015. Rates may change as the insured enters a higher age category or if the plan experience requires a change for all insured.